INMATE MENTAL HEALTH INFORMATION FORM

INMATE INFORMATION

FULL LEGAL NAME: _____ DATE OF BIRTH:_____

ADDRESS BEFORE PRISON: _____

CDCR #: _____HOUSING, IF KNOWN: _____

FAMILY CONTACT INFORMATION

THIS FORM IS BEING COMPLETED BY: _____

FAMILY MEMBER WHO CAN BE CONTACTED REGARDING THIS FORM: _____

RELATIONSHIP TO INMATE: _____

ADDRESS: CITY: STATE/ ZIP: _____

DAYTIME PHONE: _____ EVENING PHONE: CELL: _____

MENTAL HEALTH INFORMATION

PSYCHIATRIST INFORMATION:

NAME: _____ ADDRESS: _____

PHONE: _____APPROXIMATE DATES OF TREATMENT: _____

PSYCHOLOGIST/ COUNSELOR INFORMATION:

NAME: _____ ADDRESS: _____

PHONE: _____APPROXIMATE DATES OF TREATMENT: _____

DESCRIBE THE INMATE'S MENTAL HEALTH HISTORY: _____

_____

_____

DIAGNOSIS: _____

MEDICATIONS: _____

Side effects or negative reactions to medications: _____

ARE YOU WORRIED THAT THE INMATE MIGHT HARM HIMSELF? NO___ YES ___

If yes, explain your concerns: _____

HAS YOUR FAMILY MEMBER ATTEMPTED SUICIDE IN THE PAST? NO ___ YES ___

If yes, provide approximately date(s) and number of suicide attempts/threats: _____

What was going on that might have triggered suicidal thoughts or behavior? _____

_____

_____

_____

MEDICAL INFORMATION

MEDICAL DOCTOR:

NAME: _____ ADDRESS: _____

PHONE: _____APPROXIMATE DATES OF TREATMENT: _____

LIST MEDICAL CONCERNS: _____

_____

MEDICATIONS: _____

R. J. DONOVAN CORRECTIONAL FACILITY CONTACT INFORMATION

PLEASE FAX OR MAIL THIS FORM TO: DR. RICK BJORKLUND, CHIEF PSYCHOLOGIST

ADDRESS: R. J. DONOVAN CORRECTIONAL FACILITY P.O. BOX 79906, SAN DIEGO, CA 92179

FAX: (619) 671-7585

NOTE: If you have any additional information you'd like to share, please attach a separate sheet. Thank you for your assistance!